BCN Advantage℠ HMO-POS

Blue Care Network of Michigan

Medicare and more

Blue Care Network of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Michigan Public School Employees' Retirement System

Medicare Advantage Plan OPT-OUT FORM

If you wish to decline coverage, complete all sections below and return to ORS. (Please print)

Name:	Relationship to Contract Holder:
Contract Holder SSN:	Medicare ID No.:
Medicare SSN (if different from Contract Holder):	
Medicare Part A Effective Date:____/____/____	Medicare Part B Effective Dates:____/____/____
Telephone No.:	Email Address:
Permanent Home Address:	
Mailing Address (if different than above):	

Important: You can only be enrolled in one Medicare plan at a time. If you are already enrolled in an individual Medicare Advantage plan or an individual Medicare Prescription Drug (Part D) plan, or if you are covered through your spouse's Medicare Advantage or Medicare Prescription Drug plan, you must decide which plan you wish to keep. If you do not notify us that you are enrolled in another plan, we will enroll you in the Michigan Public School Employees' Retirement System Medicare Advantage plan and Medicare will automatically cancel your other Medicare coverage.

Check below if you wish to opt out of Medicare Advantage

☐ I decline coverage for myself and I understand this will result in ***the termination of all medical and prescription drug coverage provided by the Michigan Public School Employees' Retirement System.***

Important: If you are the contract holder and you decline coverage, you and your dependents will be removed from medical and prescription drug coverage through the Michigan Public School Employees' Retirement System.

Once you or your representative have checked the box above and provided any requested information, please complete the information below, sign, and date.

X_____ (____)_____

Signature **Date signed** **Daytime phone number**

If you are signing as the contract holder's authorized representative, please complete the section below.

The following is authorized to act on behalf of the individual above under the laws of the State in which the individual resides. If signed by an authorized individual, this signature certifies that:

1) this person is authorized under State law to complete this opt-out form, and

2) documentation of this authority is available upon request.

Name of representative	**Daytime phone number** ( ) -
Address	**Relationship to retiree**